Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
P O BOX 24809
HOUSTON TX 77029

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
December 7, 2010

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-1185-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denial on EOB states: **Pre-Authorization not obtained**. Upon further review we have noted that the authorization number has been in the appropriate box on the cms-1500 since initial faxing."

Amount in Dispute: $728.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of injury is 5/7/10. The date of injury plus 14 days is 5/21/10. DWC Rule 134.600 at (p)(5) states, '…(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury…' The requestor provided physical therapy on 5/14/10, 5/18/10, 5/19/10, 5/21/10, 5/24/10, 5/28/10, 6/2/10, 6/7/10, 6/9/10, 6/11/10, 6/14/10, and 6/18/10… Texas Mutual denied payment ofp {sic} date 5/24/10 because preauthorization was required and not obtained. The requestor obtained preauthorization for six sessions of physical therapy to be provided within date range 5/28/10 and 6/18/10…Texas Mutual denied payment of date 6/18/10 because preauthorization was required and not obtained."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2010	97110 97112 97140	$224.00 $56.00 $112.00	$0.00 $0.00 $0.00
June 18, 2010	97110 97112 97140	$168.00 $56.00 $112.00	$0.00 $0.00 $0.00
TOTAL		$728.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 30, 2010
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   Explanation of benefits dated September 2, 2010
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
     CAC-198 – PRECERTIFICATION/AUTHORIZATION EXCEEDED.
   - 760 – PREAUTHORIZATION LIMITED SESSION/VISIT TO NO MORE THAN 1 HR; NO MORE THAN 4 CPT CODES AND NO MORE THAN 45 MINUTES OF CUMULATIVE TIMED CODES
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the physical therapy services in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   Per 28 Texas Administrative Code §134.600(p)(5)(C)(i), "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
   (i) the date of injury."

   The injured employee's date of injury was May 7, 2010. Review of the submitted documentation finds that the requestor provided physical therapy services on May 14,2010, May 18, 2010, May 19, 2010, May 21, 2010, May 24, 2010, May 28, 2010, June 2, 2010, June 7, 2010, June 9, 2010, June 11, 2010, June 14, 2010 and June 18.2010. In accordance with 28 Texas Administrative Code §134.600(p)(5)(C)(i), the injured employee's date of injury, May 7, 2010 plus 14 days is May 21, 2010, therefore disputed date of service May 24, 2010 was outside of the initial first two weeks of injury, and did require preauthorization approval prior to the services rendered therefore, reimbursement cannot be recommended.

   The respondent's preauthorization approval letter dated Jun 1, 2010, #8944944, with a start date of May 28, 2010 and an end date of June 18, 2010 specifically states, "physical therapy 3 times per week for 2 weeks", (ie, 6 sessions). As evidenced by the CMS-1500's, the requestor performed and billed physical therapy services on May 28, 2010, June 2, 2010, June 7, 2010, June 9, 2010, June 11, 2010, June 14, 2010 and June 18, 2010 for a total of 7 sessions. The Division concludes that disputed date of service was considered the 7th session rendered was not preauthorized in accordance with 28 Texas Administrative Code §134.600(p). As a result, reimbursement cannot be recommended for the disputed date of service, June 18, 2010.

2. The requestor is not entitled to additional reimbursement. As a result, the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 10, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.